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ABSTRACT

Acquired Immune Deficiency Syndrome (AIDS) is undisputedly the most significant public health problem facing the Black community today. From the outset, it was apparent that the disease disproportionately affected Blacks. In 1981, when AIDS was first identified, 21.5 percent of the first 107 cases were Blacks and Hispanics. This report discusses the following issues: (1) heterosexual spread of AIDS; (2) reporting of AIDS in the Black community; (3) peculiar clinical manifestations of AIDS in Blacks; (4) stigmatizing of Haitians in the United States; (5) the hemophiliac response to AIDS; (6) the gay movement response to AIDS; and (7) AIDS in Africa. The best epidemiological evidence suggests that the Black community should concentrate on the following primary means of transmittal of the virus: (1) sexual contact; (2) dirty drug needles; and (3) infection at birth as a result of the mother's disease. Recommendations for each of these are made. Because the educational system is failing for Blacks, AIDS education in the schools will probably have little effect on the prevalence of the disease in the Black community. The Black community must work to solve the social, economic, and educational problems that contribute to the spread of AIDS. Data are presented on 2 tables. A bibliography of 17 items is included. (BJV)

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A Perspective on AIDS: A Catastrophic Disease But a Symptom of Deeper Problems in the Black Community

by

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Acquired Immune Deficiency Syndrome (AIDS) is undisputedly the most significant public health problem facing the Black community today.

AIDS is an infectious disease known to be caused by a virus, Human Immunodeficiency Virus (HIV). This virus mainly attacks the body's immune (T4+ Helper/inducer lymphocytes) and neurological systems. The most outstanding feature of the disease is that it renders the body defenseless against otherwise non-fatal infectious agents and certain cancers (Ho, Pomerantz, Kaplan, 1987). First identified in 1981, AIDS is a disease that once it has manifested itself is almost uniformly fatal. AIDS has no known cure or vaccine. To date over 50,000 United States cases have been documented by the Centers for Disease Control (CDC).

From the outset, it was apparent that AIDS disproportionately affected Blacks. In 1981, CDC noted that 21.5 percent of the first 107 cases of previously healthy persons displaying AIDS-related symptoms were Blacks and Hispanics, most of whom were homosexual/bisexual males (Houston-Hamilton, 1986).

AIDS in the United States occurs chiefly in two populations: male homosexuals/bisexuals, and intravenous drug users. These two groups represent 90 percent of reported U.S. cases of AIDS.

HETEROSEXUAL SPREAD OF AIDS

If the heterosexual spread of AIDS is of major concern to public leaders and the public at large, it should be of dominant concern to Black people. Whereas heterosexual transmission represents only 4 percent of the total AIDS cases, heterosexual transmission represents 11 percent of the cases of AIDS in Blacks. Blacks represent 70 percent of the cases of heterosexual transmission of AIDS (Centers for Disease Control, 1987).

In the Black community, the HIV infection rate via IV drug use has grown. In Newark, N.J., 61 percent of the new cases of AIDS are reported to be intravenous drug users (Institute of Medicine, National Academy of Sciences, 1986). Blacks (51%) and Hispanics (29%) are overwhelmingly represented in the IV drug population (See Table 1). Therefore, heterosexual Black and Hispanic people who are sexual partners of HIV-infected heterosexual drug users become one of the obvious "bridges" of transmitting HIV infection to the remainder of the heterosexual community.

REPORTING OF AIDS IN THE BLACK COMMUNITY

AIDS is only one, although the most malignant, manifestation of HIV infection. For every person with AIDS, there are an estimated 100 persons infected with HIV without any sign of disease or lesser manifestations of disease. Physicians and other health providers are generally required to report only AIDS and not HIV infection. Because male homosexuality/bisexuality and intravenous drug use are the predominant risk factors in the U.S., it is obvious that in addition to having a devastating disease there is the added social stigma attached to being infected with HIV.

Because of racial factors and the relatively low socio-economic status of most Blacks, one can reasonably expect that the dominant medical establishment will have a strong proclivity to report more stringently AIDS cases in Blacks, Hispanics and lower socio-economic groups as compared to middle and upper class whites. Medicine has a long history of this type of bias towards reporting diseases. For example, in the 1800's, physicians readily identified tuberculosis as such in the poorer classes and called the same illness a "melancholia" when it occurred in upper classes (Swan, 1985).

In addition, there is the perennial undercounting of Blacks in the population census. This would make AIDS incidence, mortality, morbidity and other population-based rates falsely high. Even taking these factors into account, it appears that AIDS is more likely to be under-reported in whites than over-reported in Blacks.

PECULIAR CLINICAL MANIFESTATION OF AIDS IN BLACKS

Recent reports indicate that Black AIDS victims are dying at faster rates than other persons with AIDS (Mason, 1987). Blacks with AIDS have been found to have a higher incidence of manifestation from opportunistic infections when compared to whites, and a lower incidence of Kaposi's Sarcoma. Any number of possibilities exist as an explanation for these occurrences, ranging from the lack of access to quality medical services to pre-existing poor health of Blacks. However, to date, neither CDC nor other national public health authorities have reported any detailed explanations for these findings.

STIGMATIZING OF HAITIANS IN THE UNITED STATES

AIDS was first reported in Haitians in 1982 (Hockstader, 1987); based on only a few initial cases, incidents of HIV infection in the Haitians were initially over-estimated. Since that time, CDC

TABLE 1

United States Cases Reported to CDC as of September 21, 1987

Transmission Categories[2]	Black Not Hispanic Cumulative Number	(%)	Total Cumulative Number	(%)
ADULTS/ADOLESCENTS				
Homosexual/Bisexual Male	4046	(40)	27483	(66)
Intravenous (IV) Drug Abuser	3473	(35)	6853	(16)
Homosexual Male and IV Drug Abuser	696	(7)	3129	(8)
Hemophilia/Coagulation Disorder	20	(0)	379	(1)
Heterosexual Cases[3]	1151	(11)	1644	(4)
Transfusion, Blood/Components	128	(1)	882	(2)
Undetermined[4]	508	(5)	1232	(3)
SUBTOTAL [% of all cases]	10022	[24]	41602	[100]
CHILDREN[5]				
Hemophilia/Coagulation Disorder	5	(2)	31	(5)
Parent with/at risk of AIDS[6]	282	(89)	456	(79)
Transfusion, Blood/Components	19	(6)	70	(12)
Undetermined[4]	10	(3)	23	(4)
SUBTOTAL [% of all cases]	316	[54]	580	[100]
TOTAL [% of all cases]	10338	[25]	42182	[100]

[2]Cases with more than one risk factor other than the combinations listed in the tables or footnotes are tabulated only in the category listed first.
[3]Includes 902 persons (196 men, 706 women) who have had heterosexual contact with a person with AIDS or at risk for AIDS and 742 persons (582 men, 160 women) without other identified risks who were born in countries in which heterosexual transmission is believed to play a major role although precise means of transmission has not yet been fully defined.
[4]Includes patients on whom risk information is incomplete (due to death, refusal to be interviewed or loss to follow-up), patients still under investigation, men reported only to have had heterosexual contact with a prostitute, and interviewed patients for whom no specific risk was identified.
[5]Includes all patients under 13 years of age at time of diagnosis.
[6]Epidemiologic data suggest transmission from an infected mother to her fetus or infant during the perinatal period.

estimates of the incidence of HIV infection in Haitians has been revised down from 4.5 percent before 1984 to 1.5 percent in 1986 (Institute of Medicine, National Academy of Sciences, 1986). The actual incidence among the many Haitians who have been in this country for years is not fully known but it is reasonable to expect that these Haitians have even a lower incidence of infection. In 1985, CDC officially dropped Haitians in the United States as a "high risk" AIDS group. Nonetheless, Haitians in this country remain stigmatized by this official CDC mislabeling.

In fact, the case for labeling all men from San Francisco as high risk has just as much public health justification. It is estimated that homosexual/bisexual males represent at least 25 percent of the male population in San Francisco (Institute of Medicine, National Academy of Sciences, 1986). Current estimates state that 37 percent to 75 percent of homosexual/bisexual males are infected (Jones et al., 1987). Thus, it can be conservatively estimated that 9.25 percent of the men from San Francisco are infected when compared to 1.5 percent of the Haitian population (Jones et al., 1987).

While CDC was quick to prematurely label all Haitians as a high risk group, the public health response has been slow and relatively weak in alerting the Black community to the threat posed by AIDS. Only recently have federal public health authorities forcefully advocated for programs in the Black and Hispanic community (Mason, 1987). Even today, when it is fashionable for Blacks and Whites alike to advocate "education and counseling" in the high-risk community, a relatively small portion of public monies is allocated for Black communities. The mere $7 million nationally for AIDS education in the Black community is roughly equivalent to the cost of a single issue of a daily newspaper for each Black person in the United States.

THE HEMOPHILIAC RESPONSE

Contrast the belated and anemic federal support for AIDS prevention in the Black community with the federal response to hemophiliacs. In 1986, federal funds were appropriated for AIDS counseling and education. A total of $2.5 million was earmarked for hemophiliacs (a group 83% white and a high risk AIDS group) (National Hemophilia Foundation, 1987). Hemophiliacs who received contaminated blood products in the past are an extremely high risk group. Between 32 percent to 92 percent of the hemophiliacs who received blood products before 1984 have HIV infection. Since that time, procedures for sterilizing the blood products used by hemophiliacs (MMWR, 1987) and methodologies for screening the blood supply for HIV have been applied. Therefore, from a public health perspective, hemophiliacs as a group will become a progressively smaller at-risk group.

Interestingly enough, the federal government never instituted a similar program for hematologic patients, people with sickle cell disease. While persons with sickle cell disease, as a rule, did not receive the same concentrated blood products (clotting factors) as the hemophiliacs, many persons with sickle cell disease received multiple transfusions with HIV-infected blood. There is little doubt that persons with sickle cell disease who received multiple transfusions were at high risk of HIV infection. While large scale studies on the incidence of HIV infection in persons with sickle cell disease have not been performed, there are many case reports by sickle cell clinicians of HIV infection in sicklers. Given the large number of persons with sickle cell disease, 50,000 Black Americans annually (Howard University Center for Sickle Cell Disease) as compared to 20,000 hemophiliacs, (National Hemophilia Foundation), there is apparently little public health policy justification for instituting a program for hemophiliacs and not one for sicklers.

THE GAY MOVEMENT RESPONSE TO AIDS

It has been known for years that homosexual/bisexual males have been at high risk for sexually transmitted disease. In retrospect, it is not surprising that a new sexually transmitted disease when planted in the male homosexual/bisexual community would flourish.

Blacks, as a group, are at higher risk than whites of having a sexually transmitted disease but in addition, Blacks are at greater risk of being intravenous drug users. These two conditions put Blacks at double risk.

In contrast to the Black community, the response of of the white Gay movement to AIDS has been swift and effective. White homosexual/bisexuals have exerted their influence on AIDS policy and programs from the outset of the discovery of AIDS. In every community in which AIDS is prevalent, they are potent political forces. Moreover, not only have monied white homosexual/bisexuals donated funds to the cause, they have put in much time in voluntary humanitarian services to educate and aid their fellow homosexual/bisexuals. Although their work in many cases was too late, the work of the Gay movement to combat AIDS is beginning to pay off.

White homosexual/bisexuals appear to be reducing their high-risk AIDS status; for example, as devastatingly ill Black and Hispanic AIDS babies (mostly the products of drug-abusing mothers or fathers) were accumulating in Northeastern hospitals, such as Harlem Hospital in New York City, white homosexual/bisexuals in New Mexico, New York and San Francisco had fewer cases of sexually transmitted diseases (STDs) (gonorrhea, syphilis) than in previous years (Jones et al. 1987). In spite of the high prevalence of the HIV virus in the homosexual/bisexual population, public health officials concede that this drop in STD in male homosexuals demonstrates reduced risk in contracting HIV infection. In addition, it is believed that STD may be an important co-factor in converting an asymptomatic HIV infected person into a full blown AIDS patient. Thus, it is possible that the decrease in STD in male homosexuals will prevent or delay AIDS in those already HIV infected (Institute of Medicine, National Academy of Sciences, 1986).

AIDS IN AFRICA

Inevitably, AIDS will kill thousands of people in the U.S. and many millions in Africa. The U.S. press and public health establishment have been intensely interested in Africa and the Caribbean, because AIDS appears to be spreading there heterosexually (Institute of Medicine, National Academy of Sciences, 1986). For example, reports of the 3rd International Conference on AIDS cite that the masses of people in Central Africa in the rural areas are largely not HIV infected. The distribution of the HIV virus in East and Central African countries (e.g., Zaire, Zambia, Burundi, Rwanda, Uganda, Tanzania) appears to be more restricted to the "urban areas. In South Africa the distribution of HIV is along the truck routes taken by the migrant Black male mine workers, displaced from their families, imported from surrounding Black nations. These routes are the strongholds of the HIV-infected female prostitutes (3rd International Conference on AIDS).

HIV infection in Africa is not yet at pandemic levels, but HIV infection is firmly seated in Africa. It does not strain the imagination as to the impact that AIDS will have on Africa and the poorer Caribbean countries such as Haiti when one considers the case of measles. Today 50,000 African children die of measles, a disease with an available vaccine. Measles is the single leading cause of childhood death in Africa. In many instances 1/3 of the children die before the age of six years (UNICEF, 1986). This illustrates the extremely limited capacity of African countries to respond to a disease, unlike AIDS, that is practically 100% preventable.

A REASONABLE RESPONSE TO THE AIDS EPIDEMIC IN THE BLACK COMMUNITY

Blacks already infected with HIV will need both financial and human services. Clearly, federal, state and local governments should provide resources for these services. The Black community groups should be strong advocates of and provide additional financial and human services to the Blacks already HIV-infected. There is an obvious role that the Black churches and other community groups should play in this area.

Blacks are over-represented among those infected with HIV; but 99% of Blacks are not infected. HIV infection is not a "Black" or "Hispanic" disease. The Black community should resist the label.

"Where you see hoof prints do not look for zebras." HIV virus has been found to be in most body fluids; to survive outside of the body for 36 hours (MMWR, 1987) and is found in mosquitoes. It has been contended that the virus was introduced into the Black community as part of a White conspiracy (personal communication at a church conference on AIDS). These reports vary from being technically true to being outlandish. The Black community should be aware of all new information about HIV infection; but *the best epidemiological evidence suggests that the Black community concentrate on three primary means of transmittal of the virus: (1) Sexual contact; (2) dirty drug needles and (3) being born of a mother infected with HIV.*

Sexual Contact: The Black community should promote programs, policies and practices that decrease sexual promiscuity and promote discretion in selecting sexual partners. A major step would be the promotion of monogamous sexual relationships, especially Black marriages. Marriage is an institution that is being wholeheartedly abandoned by young Black people. According to the D.C. Department of Human Services, in 1986, 92.8 percent of births to Black women under age 20 were to single mothers.

Non-monogamous sexually active persons should properly use condoms and spermicide and avoid anal intercourse. Condoms are not failsafe but are reported to be about 83 percent effective in preventing the spread of HIV infection (Goedert, 1987).

The voluntary testing for the HIV antibody and counseling should be encouraged in the Black community. However, Blacks should stand with the Gay movement in watch-dogging the issues of confidentiality of reporting in regard to the HIV antibody test.

Black homosexuals/bisexuals have special problems of social rejection not completely shared with their white counterparts (National Coalition of Black Lesbians and Gays, 1986). These differences should be acknowledged and preventive health programs directed to minimize HIV transmission in Black homosexual/bisexual males.

Dirty Drug Needles: Obviously, programs that treat and prevent drug abuse should be promoted in the Black community. Sterile needles should be made available to the addicted population. In addition, the addicts should be taught to sterilize their needles by simply using a diluted solution of household bleach.

Children Born to an HIV-Infected Mother: About 80 percent of children with AIDS are Black or Hispanic. All pregnant women should be offered the HIV test and be given appropriate counseling. An HIV-infected pregnant woman should be given the most current available information to protect her health and that of her unborn child. According to recent data, the risk of transmittal of HIV to the unborn is 30 percent to 60 percent. The reports of the International Conference point to strong evidence that the chances of an infected woman passing the virus to her unborn child are nearly 50 percent.

AIDS EDUCATION IN SCHOOL

The federal government is undertaking a relatively anemic effort to educate the minority community about AIDS (See Table 2). The Surgeon General has recommended that AIDS education be taught at the elementary school level. It is difficult not to look at these educational proposals without a jaundiced eye. How can the public leadership be preaching AIDS education, when by almost every measure the education system is failing Blacks.

Fewer Blacks are going into higher education than in previous years. The urban Black grade and high schools continue to languish far below an acceptable level of academic achievement. Blacks, particularly males, are dropping out of school in record numbers. In the health professions (medicine, professional nursing, and dentistry), Blacks are severely under-represented. Enrollment in these areas continues to decline. Clearly, one cannot be sanguine about the efficiency of AIDS education in the schools.

TABLE 2

Summary of PHS Funding For AIDS

1982	$ 5.5 million
1983	$ 28.7 million
1984	$ 61.5 million
1985	$108.6 million
1986	$233.8 million
1987	$494.1 million ($30 million, on a one-time only basis, to cover the cost of AZT. $130 million for AIDS information, health education, and risk reduction. $129 million for effective treatment in FY 1987).

In the 1987 supplemental appropriation, $7 million were made available to initiate a special emphasis on preventing AIDS among minorities at risk.

GENERAL RECOMMENDATIONS

In addition to AIDS, most major communicable diseases (tuberculosis, syphilis, viral hepatitis, pelvic inflammatory disease, diphtheria, pertussis) inordinately affect Blacks (Report of the Secretary's Task Force On Black And Minority Health, 1985). Research does not show that Blacks are in fact genetically more susceptible; however, economic, educational, nutritional and environmental influences, as well as the inadequacies of the health care systems are the major contributors (Williams, 1975).

AIDS is an infectious disease that is growing in the Black community. The Black community must not only deal with the exigency of this particular disease but work to remove the root causes that contribute to its spread. A careful examination of contributing factors to AIDS in the Black community will reveal some very old interrelated problems: social disruption with the dismantling of the Black family; weakened Black education and training systems; weakened Black economy; growing social and economic influences of the criminal justice system fueled by drugs and alcohol; unhealthy environmental conditions; negative treatment by the media; and the diminution of the values of Black culture and history.

Oddly enough, what the Black community does to defeat these old enemies will contribute to the fight against a new one, AIDS.

REFERENCES

Acquired immunodeficiency syndrome (AIDS) among Blacks & Hispanics—United States (1986). *Morbidity and Mortality Weekly Report, 35(42)*, 655–666.

Centers for Disease Control, *Weekly Surveillance Report*, September 21, 1987.

Epidemiology—AIDS in Developing Countries (1987, June). Session of 3rd International Conference on AIDS, Washington, D.C.

Goedert, J. (1987). What is safe sex? Suggested standards linked to testing for human immunodeficiency virus. *New England Journal of Medicine, 316(21)*, 1339–1342.

Ho, D., Pomerantz, R., Kaplan, J. (1987). Pathogenesis of infection with human immunodeficiency virus. *New England Journal of Medicine, 317(5)*, 278–286.

Hockstader, L. (1987). "AIDS in Haiti." *Washington Post Health*, 12–17.

Houston-Hamilton, D. (1986). A constant increase: AIDS in ethnic communities. *Focus, 1(11)*, 1–2.

Institute of Medicine, National Academy of Sciences (1986). *Confronting AIDS: Directions for public health, health care and research*, Washington, D.C.: National Academy Press.

Jones, C., Waskin, H., Gerety, B., Skipper, B., Hull, H. and Merty, G. (1987). Persistence of high-risk sexual activity among homosexual men in an area of low incidence of the acquired immunodeficiency syndrome. *Journal of the American Venereal Disease Association, 14(2)*, 79–82.

Mason, J. (September, 1987). Statement made at the Congressional Black Caucus Health Braintrust, Washington, D.C.

National Coalition of Black Lesbians and Gays (1986). Position Paper.

National Hemophilia Foundation (October, 1987).

Recommendations for prevention of HIV transmission in health-care settings (1987). *Morbidity and Mortality Weekly Report, 36(25)*, 35–185.

Report of Secretary's Task Force on Black and Minority Health, DHHS, (October, 1985).

Survey of Non-U.S. hemophilia treatment centers for HIV seroconversions following therapy with heat treated factor concentrates (1987). *Morbidity and Mortality Weekly Report, 36(9)*, 121–124.

Swan, P. (1985). History of TB. *Nursing Times, 81*, 47–49.

UNICEF (1986). *State of the world's children 1986*.

Williams R. A. (1975). *Textbook of Black-related diseases*. New York: McGraw Hill.

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